W-1648-001

Printed: 12/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE. ZIP CODE		
		D REHABILITATON	215 EVE	RGREEN A	VE		
we said				ATTOX, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPI DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ryspisjaliani karinga		K 000	ekskoperklastikere koperkan n. m dan distataka salepatrasia distata distata distata da saren erren erren e	en erkelden mikrelik den erkerken erkerken kalle kolongen erkerken erkerken erkerken erkerken erkerken erkerke	Agenement But for fundament daig glid day (symholid acuto) gat fir sugarci (effective
	Surveyor: 21761		*	, ,			
	Construction Type:	V(111)			Appomattox Health Rehabilitation Cent		
	Number of stories:	One Story	v .		Marshall POC.		
	building of wood fra	 The facility is a one irne construction with ated from the two-stor r rated barrier wall. 	concrete		The facility desires to Correction be considerable facility's allegation of the Constant of th	dered the	f
	and protected by N	The building is fully sp IFPA #13 systems su itic water tank and a c	pplied by		The statements mad are not an admissio constitute agreeme alleged deficiencies	n and do not nt with the	
	Safety Code survey accordance with 42 Part 483: Requirem Facilities. The facil compliance using the regulations. The facilities are supplied to the facilit	tandard recertification was conducted 12/16 Code of Federal Reg nents for Long Term C ity was surveyed for he LSC 2012 Existing cility was not in comp ents for Participation N	6/16 in julation, are	A constant			
	compliance with Tit	llow demonstrate non le 42 Code of Regulat ife Safety from Fire.)					
	NFPA 101 Protection	on - Other			к 300		
K 300 SS=F	Protection - Other List in the REMARI 18.3 and 19.3 Prote	KS section any LSC S ection requirements the provided K-tags, but	at are	K 300	A PM will be annual audit/ rated doors. in process of	test of fire All units are	

by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDE SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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		MATTOX, VA	and the second s	INVESTIGATION OF COMPANY AND ADMINISTRATION AND ADM		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE	PLAN OF CORRECTION (I ACTION SHOULD BE CR CED TO THE APPROPRIA' DEFICIENCY)	OSS-	(X5) COMPLETION DATE
K 300	Continued From page 1	K 300	2.	Maintenance Dire	ector to	
	deficient. This information, along with the			review PMs and v	vhen due	
	applicable Life Safety Code or NFPA standard	,		have survey/tests	ì	
	citation, should be included on Form CMS-2567.			completed and		
		\$		documented on N	∕IFA	
				forms.		
	This formation is not made as a side and have		3.	Corporate will add	d PMs to	
	This Standard is not met as evidenced by: Surveyor: 21761	\$		Maintenance syst	em for	3
	Based on observation and interview, it was			review and follow	-up as	:
	revealed the facility failed to test rated doors,			necessary.		
	evidenced as follows;		4.	Facility will have		
	Findings include:			Maintenance Dire	ctor	
	r mongs morace.			report any occurre	ences of	
	On 12/16/16 upon records review, at			door issues to the		
w.,	approximately 1:35 P.M., it was observed that			Safety/QA commi	ttee for	
	documentation could not be provided for rated door periodic testing and inspection. (Sections			review and action.	s needed	
	7.2.1.15.2, 7.2.1.15.3, 7.2.1.15.4)			to ensure complia	nce.	
		•	5.	Facility desires a T		
	The Administrator witnessed this evidence by observation and interview.	:		Limited waiver to		
	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)	K 325		3-20-	17	
	Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1,	3 3 *				
	unless all conditions are met: * Corridor is at least 6 feet wide		K 325			
	* Maximum individual dispenser capacity is 0.32	:	1.	HK Director impler	nented	
	gallons (0.53 gallons in suites) of fluid and 18		33500° S	an Alcohol Based h		
	ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Rub Dispenser Tes		
	horizontal spacing	!		on 12/21/2016	0	
	* Not more than an aggregate of 10 gallons of		2	HK Director or des	ianee to	
	fluid or 135 ounces aerosol are used in a single		Aling 4	review the log dail	-	
	smoke compartment outside a storage cabinet, excluding one individual dispenser per room			for compliance.	å rart	
	* Storage in a single smoke compartment greater	•		in weighten.		

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NAME OF P	ROVIDER OR SUPPLIER STREET ADDR	RESS, CITY, STATE	E, ZIP CODE
APPOMA		ERGREEN AV IATTOX, VA	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 325	than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to perform ABHR testing, evidenced as follows;	K 325	 All ABHR dispensers and documentation reviewed monthly by the HK Director and any issues will be addressed immediately. Process will be reviewed in QA committee for two quarters. 12/21/2016
K 711 SS=F	On 12/16/16, upon review of documentation at approximately 11:45 am, it was observed during inspection that documentation for the Alcohol Based Hand Rub automatic dispensers testing was not available. Automatic dispensers are located throughout the facility in sleeping area corridors. The Administrator witnessed this evidence by observation and interview. NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff	K 711	K 711 1. 12-23-2016 Updated the Departmental Fire Plan instructions to include the removal of wheeled equipment stored in the corridors. (HK, Nurses, and CNAs)

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NAME OF PRO	OVIDER OR SUPPLIER STREET	T ADDRESS, CITY, S	TATE, ZIP COD		
APPOMAT	3	5 EVERGREEN PPOMATTOX, V			
(X4) ID PREFIX (E TAG	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA' OR LSC IDENTIFYING INFORMATION)	TORY PREFIX TAG	CORREC	ER'S PLAN OF CORRECTION (EACH CTIVE ACTION SHOULD BE CROSS- RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
P S S S S S S S S S S S S S S S S S S S	Continued From page 3 per 18/19.7.2.1.2 and provides for all of the finality plan components per 18/19.2.2. 8.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2. 8.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2. 9.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was evealed the facility failed to provide complete emergency procedures, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 12:20 P.M., it was observed the written emergency procedures did not include emoval of wheeled equipment stored in corridors. The Administrator witnessed this evidence by observation and interview. IFPA 101 Fundamentals - Building System Categories Suilding systems are designed to meet Categories through 4 requirements as detailed in NFPA Categories are determined by a formal and locumented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	the K 901	3. 4. 5.	Fire Plan to be reviewed monthly by the Maintenance Director and Administrator to ensure all wheeled equipment are identified for removal and where to store. Maintenance Director to monitor monthly during unannounced fire drills for compliance. Process will be reviewed by QA committee for 2 quarters. 12-23-2016 Forms created, added new PM and facility entering information to comply with NFPA 99- Chapter 4.	
T S B	This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was evealed the facility failed to provide a formal a locumented catagory risk assessment,	and	3. 4.	monitor PMs and complete when due.	

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B. WING

12/16/2016

NAME OF PROVIDER OR SUPPLIER

APPOMATTOX HEALTH AND REHABILITATON

STREET ADDRESS, CITY, STATE, ZIP CODE

215 EVERGREEN AVE APPOMATTOX, VA 24522

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY
TAG OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

K 901

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

K 901 Continued From page 4 evidenced as follows;

Findings include:

On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed that no documentation could be provided for a formal and documented risk assessment.

The Administrator witnessed this evidence by observation and interview.

K 915 NFPA 101 Electrical Systems - Essential Electric SS=F Syste

Electrical Systems - Essential Electric System Categories

*Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES.

*General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES.

*Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours.

3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3

This Standard is not met as evidenced by: Surveyor: 21761

Based on observation and interview, it was revealed the facility failed to provide electrical systems documentation, evidenced as follows; 5. Facility desires a Time
Limited waiver to expire
(correction date)

3-20-17

K 915

K 915

- Forms created, added new PMs and facility entering information to comply with NFPA 99. Essential Electric System Categories.
- Update annually to ensure any occurrences are not missed.
- Maintenance Director will monitor PMs and complete when due.
- Safety/QA committee to review the process and be notified of any issues for correction to be made.
- 5. Facility desires a Time
 Limited waiver to expire
 3-80-19 (Correction
 Date).

Printed: 12/22/2016 FORM APPROVED OMB NO. 0938-0391

COMPLETION

DATE

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B. WING

12/16/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

APPOMATTOX HEALTH AND REHABILITATION

215 EVERGREEN AVE APPOMATTOX, VA 24522

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX OR LSC IDENTIFYING INFORMATION) TAG TAG K 915 Continued From page 5 Findings include: On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed there was no catagory documentation provided for essential electrical systems. The Administrator witnessed this evidence by observation and interview. K 923: NFPA 101 Gas Equipment - Cylinder and SS=F Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order

K 915

K 923

K923

PROVIDER'S PLAN OF CORRECTION (EACH

CORRECTIVE ACTION SHOULD BE CROSS-

REFERENCED TO THE APPROPRIATE

DEFICIENCY)

- 1. (2) signs ordered 12/20/2016 to include Caution: Oxidizing Gases stored within, No Smoking. (Locations: Oxygen room and Occupational Therapy storage room)
- 2. Maintenance Director to review selected doors daily for compliance.
- 3. All doors will be reviewed monthly during scheduled fire drills for proper wording on all oxygen storage rooms.
- 4. Process and proper signage will be reviewed in QA committee for two quarters.
- 5. 01-13-2017

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8. WING

12/16/2016

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER APPOMATTOX HEALTH AND REHABILITATION 215 EVERGREEN AVE APPOMATTOX, VA 24522 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION 10 (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CORRECTIVE ACTION SHOULD BE CROSS-PREFIX DATE OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 923 K 923 Continued From page 6 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to properly mark medical gas storage, evidenced as follows; Findings include: On 12/16/16 at various times it was observed during inspection the Occupational Therapy room storage closet, and oxygen storage rooms signage throughout the facility did not include the wording ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING", at a minimum. The Administrator witnessed this evidence by observation and interview.

W-1658-002

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AND	D)	MA	n	FF	ORR	FOR	TON	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING 02 - MAIN BUILDING 02

(X3) DATE SURVEY COMPLETED

495188

8 WING

12/16/2016

APPOMATTOX HEALTH AND REHABILITATON 215 EVERGREEN AVE APPOMATTOX, VA 24522 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) K 000 INITIAL COMMENTS STREET ADDRESS, CITY, STATE ZIP CODE 215 EVERGREEN AVE APPOMATTOX, VA 24522 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION STATE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000	(XS) COMPLETION DATE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CORRECTIVE ACTION SHOULD BE CROSS- TAG OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
K 000 INITIAL COMMENTS K 000	and a second decrease of the second decrease
Surveyor: 21761	
Construction Type: II(111)	
Number of stories: Two Stories	
Building description: The facility is a two-story building separated from the one-story main building by a 2-hour rated barrier wall. The first floor contains the dining area, kitchen, and Physical Therapy Gym. The basement contains the mechanical room and laundry facility. There are no sleeping areas in this building.	
Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by a 30,000 gallon static water tank and a diesel fire pump.	
An unannounced standard recertification Life Safety Code survey was conducted 12/16/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid.	
The findings that follow demonstrate non- compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	
NFPA 101 Building Construction Type and Height K 161 SS=D Building Construction Type and Height	
	(6) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER APPOMATTOX HEALTH AND REHABILITATON 215 EVERGREEN AVE APPOMATTOX, VA 24522 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) Ю (X4) ID COMPLETION CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX DATE OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 161 K 161 Continued From page 1 K 161 2012 EXISTING 1. Fire rated ceiling to be Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by repaired at the corridor 19.1.6.2 through 19.1.6.7 beside Physical Therapy. 19.1.6.4, 19.1.6.5 2. Maintenance Director to Construction Type review this area weekly to I (442), I (332), II (222) Any number of ensure there is not a stories breach in the membrane. non-sprinklered and 3. Maintenance Director to sprinklered review monthly during 11 (111) One story scheduled fire drills to non-sprinklered ensure that the 1 hour fire Maximum 3 stories rated ceiling construction sprinklered is intact. Not allowed 11 (000) 4. Process will be reviewed non-sprinklered in QA committee for two III (211) Maximum 2 stories 4 quarters. sprinklered 5 IV (2HH) 5. 1-20-2016 6 V (111) Not allowed III (200) non-sprinklered V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This Standard is not met as evidenced by: Surveyor: 21761

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STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER APPOMATTOX HEALTH AND REHABILITATON 215 EVERGREEN AVE APPOMATTOX, VA 24522 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH m (X4) ID CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX DATE OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY K 161 K 161 Continued From page 2 Based on observation and interview, it was revealed the facility falled to maintain rated construction, evidenced as follows; Findings include: On 12/16/16 at approximately 2:50 P.M., it was observed there was a breach in the membrane of the 1-hour rated ceiling construction in the corridor at Physical Therapy. The Administrator witnessed this evidence by observation and interview. K 222 NFPA 101 Egress Doors K 222 K 222 SS=F Egress Doors 1. A. 12-19-2016 (Amped) Doors in a required means of egress shall not be adjusted the stairwell equipped with a latch or a lock that requires the delayed locking device use of a tool or key from the egress side unless using one of the following special locking from 30 seconds to 15 arrangements: seconds as marked. B. 12-CLINICAL NEEDS OR SECURITY THREAT 16-2016 Basement rear LOCKING exit door disabled and Where special locking arrangements for the clinical security needs of the patient are used, then was adjusted to only one locking device shall be permitted on provide egress to the each door and provisions shall be made for the outside by depressing the rapid removal of occupants by: remote control of delayed locking device, locks; keying of all locks or keys carried by staff at all times; or other such reliable means releasing within 15 available to the staff at all times. seconds. (Henderson 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 Electric) On 12-19-2016 SPECIAL NEEDS LOCKING ARRANGEMENTS (Amped) added lock tight Where special locking arrangements for the safety needs of the patient are used, all of the to the thumb screw for Clinical or Security Locking requirements are ensure compliance. being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is

protected by a supervised automatic sprinkler

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

APPOMATTOX HEALTH AND REHABILITATON (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (CACH DEFICIENCY) (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (CACH DEFICIENCY) (CACH DEFICIENCY) (CRECT MEACH ACTION SHOULD BY ACTION TO REFER NOTES (CORRECTIVE ACTION SHOULD BY ACTION TAG (CACH DEFICIENCY) (CACH DEFICIENCY) (CACH DEFICIENCY (CRECT MEACH ACTION SHOULD BY ACTION TAG (CACH DEFICIENCY) (ACH DEFICIENCY) (CRECT MEACH ACTION SHOULD BY ACTION TAG (CACH DEFICIENCY) (ACH DEFICIENCY) (CRECT MEACH ACTION SHOULD BY ACTION TAG (CACH DEFICIENCY) (ACH DEFICIENCY) (CACH DEFICIENCY (CRECT WE ACTION SHOULD BY ACTION TAG (CACH DEFICIENCY) (ACH DEFICIENCY) (CACH DEFICIENCY) (ACH DEFICIENCY) (CACH ACTION TAG (CACH DEFICIENCY) (CACH ACTION TAG (C	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 222 Continued From page 3 system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	
system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	E CROSS- COMPLETION DATE
system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	er to
ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain delayed egress exits. This violation potentially affects 2 of 2 smoke compartments, evidenced as follows:	e d d oors

Printed: 12/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - MAIN BUILDING 02

(X3) DATE SURVEY COMPLETED

495188

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		r ADDF	RESS, CITY, ST	ATE, ZIP CODE
APPOMA			ERGREEN , IATTOX, VA	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)	ORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
	Continued From page 4 Findings include: 1. On 12/16/16 at approximately 2:54 P.M., it was observed during inspection that the stairwing delayed locking device on the egress door to the basement was releasing after 30 seconds instead of 15 seconds as marked. 2. On 12/16/16 at approximately 2:55 P.M., it wobserved during inspection that the delayed locking on the rear egress door to the outside from the basement failed to release, preventing exiting without a swipe card. The delayed locking device has been disabled until it can be repaired. The Administrator witnessed this evidence by observation and interview. NFPA 101 Protection - Other	vas	K 222	K 300
SS=F	Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-256 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to test rated doors, evidenced as follows; Findings include: On 12/16/16 upon records review, at			 A PM will be created for annual audit/test of fire rated doors. All units are in process of survey and test. Maintenance Director to review PMs and when due have survey/tests completed and documented on MFA forms. Corporate will add PMs to Maintenance system for review and follow-up as necessary.

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(X3) DATE SURVEY COMPLETED

495188

B. WING

12/16/2016

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER APPOMATTOX HEALTH AND REHABILITATON 215 EVERGREEN AVE APPOMATTOX, VA 24522 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) PREFIX CORRECTIVE ACTION SHOULD BE CROSS-PREFIX DATE OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY K 300 Continued From page 5 K 300 4. Facility will have approximately 1:35 P.M., it was observed that Maintenance Director documentation could not be provided for rated report any occurrences of door periodic testing and inspection. (Sections door issues to the 7.2.1.15.2, 7.2.1.15.3, 7.2.1.15.4) Safety/QA committee for The Administrator witnessed this evidence by review and actions needed observation and interview. to ensure compliance. K 711 NFPA 101 Evacuation and Relocation Plan K 711 5. Facility desires a Time SS=F Limited waiver to expire on Evacuation and Relocation Plan There is a written plan for the protection of all 3-20-17 patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a K 711 copy of the plan is readily available with telephone operator or with security. The plan 1. 12-23-2016 Updated the addresses the basic response required of staff Departmental Fire Plan per 18/19.7.2.1.2 and provides for all of the fire instructions to include the safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, removal of wheeled 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, equipment stored in the 19.7.2.2, 19.7.2.3 corridors. (HK, Nurses, This Standard is not met as evidenced by: Surveyor: 21761 and CNAs) Based on observation and interview, it was 2. Fire Plan to be reviewed revealed the facility failed to provide complete monthly by the emergency procedures, evidenced as follows; Maintenance Director and Administrator to ensure Findings include: all wheeled equipment are On 12/16/16 upon records review, at identified for removal and approximately 12:20 P.M., it was observed the where to store written emergency procedures did not include procedures to include the removal of wheeled 3. Maintenance Director to equipment stored in corridors. monitor monthly during unannounced fire drills for The Administrator witnessed this evidence by compliance. observation and interview. 4. Process will be reviewed

xt Page 6 of 9

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B. WING ____

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		MATTOX, VA	minimization who allowed supplements	engagagaran jala jai 14 million jala ja 18 million jala jala jala jala jala jala jala jal	· (X5)
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K 901	Continued From page 6	K 901	K 901		
	NFPA 101 Fundamentals - Building System	K 901	** ~ ~ ~ ~		
SS=F	Categories		1.	Forms created, added new	;
	Fundamentals - Building System Categories			PM and facility entering	
	Building systems are designed to meet Category			information to comply	3
	1 through 4 requirements as detailed in NFPA 99.			with NFPA 99- Chapter 4.	
	Categories are determined by a formal and		2.	Update annually to ensure	
	documented risk assessment procedure			any occurrences are not	
	performed by qualified personnel. Chapter 4 (NFPA 99)			missed.	
	Chapter of the extraol		3.	Maintenance Director will	
	3			monitor PMs and	
				complete when due.	
	This Standard is not met as evidenced by:		4.	Safety/QA committee to	
	Surveyor: 21761		**	be notified of any issues	
	Based on observation and interview, it was			for corrections to be	
	revealed the facility failed to provide a formal and	*		made.	
	documented catagory risk assessment,		ε	7 - 1	
,	evidenced as follows;		J.	Facility desires a Time	111
;	Findings include:			Limited waiver to expire 3 - (correction date)	20-11
	On 12/16/16 upon records review, at				
	approximately 11:57 A.M., it was observed that				
	no documentation could be provided for a formal				
	and documented risk assessment.				
:	The Administrator witnessed this evidence by observation and interview.				
	NFPA 101 Electrical Systems - Receptacles	K 912			
SS=D			K 912		
	Electrical Systems - Receptacles Power receptacles have at least one, separate,		1	Kitchen electrical	3
	highly dependable grounding pole capable of		di e		
;	maintaining low-contact resistance with its mating	;		receptacle ordered 12-16-	3
	plug. In pediatric locations, receptacles in patient			2016 to replace broken	
	rooms, bathrooms, play rooms, and activity			receptacle. (Henderson	
	rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.			Electrical)	

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(X3) DATE SURVEY GOMPLETED

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12/16/2016

	TTOX HEALTH AND REHABILITATION 215 EV	RESS, CITY, STA ERGREEN A	VE		
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K 912	Continued From page 7	K 912	2.	Maintenance Director to	
	If used in patient care room, ground-fault circuit			review weekly kitchen	
	interrupters (GFCI) are listed.			receptacles to ensure all	
	6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This Standard is not met as evidenced by:			receptacles are intact.	
	Surveyor: 21761		3.	Maintenance Director to	
	Based on observation and interview, it was			review receptacles	
	revealed the facility failed to maintain electrical	ŧ		monthly to ensure	
ŧ	equipment, evidenced as follows;			compliance.	
	Findings include:	\$ *	4.	Process will be reviewed	
				in QA committee for two	
	On 12/16/16 at approximately 2:43 P.M., it was			quarters.	
	observed during inspection there is a broken electrical receptacle in the kitchen.	3	5.	1-20-2017	
3	The Administrator witnessed this evidence by observation and interview.	:			
	NFPA 101 Electrical Systems - Essential Electric Syste	K 915	K 915		
30-1		1	1.	Forms created, added new	
	Electrical Systems - Essential Electric System			PMs and facility entering	*
	Categories			information to comply	
	*Critical care rooms (Category 1) in which electrical system failure is likely to cause major			with NFPA 99. Essential	
	injury or death of patients, including all rooms			Electric System	
	where electric life support equipment is required,	2		Categories.	
	are served by a Type 1 EES.		2.	Update annually to ensure	
	*General care rooms (Category 2) in which electrical system failure is likely to cause minor			any occurrences are not	
	injury to patients (Category 2) are served by a			missed.	
	Type 1 or Type 2 EES.	,	3.	Maintenance Director will	
	*Basic care rooms (Category 3) in which			monitor PMs and	
	electrical system failure is not likely to cause injury to patients and rooms other than patient			complete when due.	
	care rooms are not required to be served by an		4.	Safety/QA committee to	
	EES. Type 3 EES life safety branch has an		* #	review the process and be	
	alternate source of power that will be effective for			notified of any issues for	
	1-1/2 hours.			correction to be made.	
	3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA)			were we made.	

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STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER APPOMATTOX HEALTH AND REHABILITATON 215 EVERGREEN AVE APPOMATTOX, VA 24522 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CORRECTIVE ACTION SHOULD BE CROSS-PREFIX DATE CR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 915 K 915 Continued From page 8 5. Facility desires a Time This Standard is not met as evidenced by: Limited waiver to expire Surveyor: 21761 3-2011 (Correction Based on observation and interview, it was Datel. revealed the facility failed to provide electrical systems documentation, evidenced as follows; Findings include: On 12/16/16 upon records review, at approximately 11:57 A.M., it was observed there was no calagory documentation provided for essential electrical systems. The Administrator witnessed this evidence by observation and interview.